Appendix G: Comprehensive Crisis Services

Last Updated: 03/14/2022

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Definitions

"Assessment" means the face-to-face interaction in which the provider obtains information from the individual or other family members, as appropriate, about the individual's behavioral health status. It includes documented history of the severity, intensity, and duration of mental behavioral health care problems and issues.

“Collateral contact” means face-to-face or telephonic exchange between the behavioral health provider of an individual and the individual’s authorized representative and others engaged in the individual’s wellness for the purpose of care coordination. The following is a list of typical collateral contacts: family members, teachers, principals, primary care clinicians, guidance counselors, day care provider staff, previous therapists, attorneys or other staff from the courts, state agencies, social service agencies, outreach programs, after-school programs, community centers, and behavioral health providers at another level of care such as inpatient providers.

"Crisis intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.

“Health literacy counseling” means patient counseling on mental health, and, as appropriate, substance use disorder, and associated health risks including administration of medication, monitoring for adverse side effects or results of that medication, counseling on the role of prescription medications and their effects including side effects and the importance of compliance and adherence.

"Individual, family, or group therapy" means the application of principles, standards, and methods of the counseling profession in (i) conducting assessments and diagnoses for the purpose of establishing treatment goals and objectives and (ii) planning, implementing, and evaluating treatment plans using treatment interventions to facilitate human development and to identify and remediate behavioral health disorders and associated distresses that interfere with behavioral health.

“Peer recovery support services” means strategies and activities that include person centered, strength based planning to promote the development of self-advocacy skills;

empowering the individual to take a proactive role in the development of their plan of care; crisis support; assisting in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management and communication strategies identified in the plan of care. Caregivers of individuals under age 21 may also receive family support partners as a peer recovery support service when the service is directed exclusively toward the benefit of the individual.

“Psychiatric evaluation” means prescription medication intervention and ongoing care to prevent future crises of a psychiatric nature.

“Telemedicine assisted assessment” means the face-to-face service delivery encounter by a QMHP-A, QMHP-C, CSAC with synchronous audio and visual support from a remote LMHP, LMHP-R, LMHP-RP or LMHP-S to: obtain information from the individual or collateral contacts, as appropriate, about the individual's mental health status; provide assessment and early intervention; and, develop an immediate plan to maintain safety in order to prevent the need for a higher level of care. The assessment includes documented recent history of the severity, intensity, and duration of symptoms and surrounding psychosocial stressors.

The following definitions found in Chapter 2 of this manual, apply to this Appendix:

- Certified Pre-Screener
- Certified substance abuse counseling assistant (CSAC-A)
- Certified substance abuse counselor (CSAC)
- CSAC supervisee
- Licensed Mental Health Professional (LMHP)
- LMHP-resident (LMHP-R)
- LMHP-resident in psychology (LMHP-RP)
- LMHP-supervisee in social work (LMHP-S)
- Registered Peer Recovery Specialist (PRS)
- Qualified Mental Health Professional-adult (QMHP-A)
- QMHP-child (QMHP-C)
- QMHP-eligible (QMHP-E)

The following definitions found in Chapter 4 of this manual, apply to this Appendix:

- Care Coordination
- Psychoeducation
- Treatment Planning

Mobile Crisis Response

Mobile Crisis Response Level of Care Guidelines	
Service Definition	Mobile Crisis Response provides rapid response, assessment and early intervention to individuals experiencing a behavioral health crisis. This service is provided 24 hours a day, seven days a week. The purpose of this service includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention in the least restrictive setting, and development of an immediate plan to maintain safety in order to prevent the need for a higher level of care. Mobile Crisis Response is designed to support individuals in the following manner: • Provide rapid response to individuals experiencing a crisis situation or escalating emotional/behavioral symptoms which have impacted the individual's ability to function in their family, living situation, community, school, or work/ environment; • Meet individuals in crisis in an environment where they are comfortable to engage to facilitate quick relief and resolution of the crisis when possible; • Provide appropriate care/support/supervision in order to maintain safety for the individual and others, while avoiding unnecessary law enforcement involvement, emergency room utilization, and/or avoidable hospitalization; • Refer and link to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care (including pre-admission screening in appropriate cases conducted by a DBHDS certified pre-screener); • Coordinate with behavioral health providers providing services to the individual throughout the delivery of the service; • Deployed in real-time to the location of the identified crisis.

Critical Features & Service Components	Mobile Crisis Response is appropriate for individuals who have emergent behavioral health needs that require immediate assessment, crisis interventions, and care coordination to resolve the potential for harm to self or others. Mobile Crisis Response teams must be available to provide services to an individual in an environment where they are most comfortable and may include their home, workplace, or other convenient and appropriate setting. Teams must be able to provide services 24 hours per day, 7 days per week. Critical features of Mobile Crisis Response include: • Recovery-oriented, trauma-informed, developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles; • An approach to the individual in crisis that is sensitive to their cultural identity and demonstrates humility and respect for their lived experiences and preferences in participating in care; • Assessment and screening of behavioral health crisis needs, including screening for suicidal or homicidal risk; • When necessary and in any location where the individual may be located, DBHDS certified pre-screeners may complete screening for the purposes of involuntary commitment within this service;. • Services provided in community locations where the individual lives, works, participates in services or socializes. Locations include schools, homes, places of employment or education, or community settings; • De-escalation and resolution of the crisis, including on-site interventions for immediate de-escalation of presenting emotional or behavioral symptoms; • Brief therapeutic and skill building interventions; • Engaging peer/natural and family support; • Safety/crisis planning; • Coordination with the crisis call center; • Linkage and referral to ongoing services, supports and resources (examples: housing, peers, chaplaincy), as appropriate and least restrictive level of care including community stabilization; • Coordination and collaborate effectively and successfully with law enforcement, emergency responders, and state-certified uniform pre-screeners. Covered Services components of Mobile Crisis Response include: • Assessment, including telemedicine assisted assessment • Treatment Planning • Individual and Family Therapy • Crisis Intervention • Care Coordination • Peer Recovery Support Services • Health literacy Counseling/Psychoeducation • Pre-admission screening for involuntary commitment

Required Activities	The following required activities apply to Mobile Crisis Response: • The provider must engage with the crisis call center in accordance with DBHDS requirements prior to initiating services. • At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment to determine the individual's appropriateness for the service. This assessment must be done in-person or through a telemedicine assisted assessment. At a minimum, the assessment must include the following elements: risk of harm; functional status; medical, addictive and psychiatric co-morbidity; recovery environment; treatment and recovery history; and, engagement. The assessment requirement can also be met by one of the following: 1. Providers may choose to complete a Comprehensive Needs Assessment (see Chapter IV for requirements). 2. If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment. 3. A DBHDS approved assessment for crisis services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. • If there is an existing Crisis Education and Prevention Plan (CEPP), the provider should, at a minimum, review the CEPP and update as necessary. • Services must be provided in-person with the exception of the telemedicine assisted assessment and care coordination activities. • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: Mobile Crisis Response may only be provided in inpatient hospital settings for the explicit purpose of pre-admission screening by a DBHDS certified pre-screener. Services may be provided in a Therapeutic Group Home (TGH), Psychiatric Residential Treatment Facility (PRTF) and ASAM Levels 3. 1 – 4.0 as long as the TGH, PRTF or ARTS Provider is not also the Mobile Crisis Response Provider. Activities not authorized or reimbursed within Mobile Crisis Response: • Inactive time or time spent waiting to respond to a behavioral situation; • Pre-admission screenings performed by DBHDS certified pre-screeners who are not LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss that are not supervised directly and signed off by an LMHP; • Supervision hours of the staff; • Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers; • Contacts that are not medically necessary; • Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor; • Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision; • Respite care; temporary housing; • Transportation for the individual or family. Additional medical transportation for service needs, which are not considered part of Mobile Crisis Response, may be covered by the transportation service through the fee-for-service (FFS) Non-Emergency Medical Transportation Broker or Managed Care Organization (MCO); • Covered services that have not been rendered; • Services provided to the individual's family or others involved in the individual's life that are not to the direct benefit of the individual in accordance with the individual's needs and treatment goals identified in the individual's plan of care; • Anything not included in the Mobile Crisis Response description; • Any intervention or contact not documented or consistent with the approved CEPP goals, objectives, and approved services.
Mobile Crisis Response Provider Participation Requirements	
Provider Qualifications	Mobile Crisis Response providers must be licensed by DBHDS as a provider of crisis stabilization services and be credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS. Mobile Crisis Response providers must follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS required training for this service. Mobile Crisis Response providers must have an active Memorandum of Understanding with a regional crisis hub via DBHDS by June 30, 2022.

Staff Requirements

Mobile Crisis Response providers must meet **at least one** of the below team staffing composition requirements (#1-5).

#	Team Composition (s)
1	1 Licensed[x]
2	1 QMHP-A/QMHP-C/CSAC[x] **and** 1 PRS **or** 1 QMHP-A/QMHP-C/CSAC[x] **and** 1 CSAC-A
3	1 Licensed[x] **and** 1 PRS **or** 1 Licensed[x] **and** 1 CSAC-A
4	2 QMHPs (QMHP-A, QMHP-C, QMHP-E) – team compositions cannot consist or 2 QMHP-Es **or** 2 CSACs[x] **or** 1 QMHP-A/QMHP-C **and** 1 CSAC[x]
5	1 Licensed[x] **and** 1 QMHP(QMHP-A, QMHP-C or QMHP-E) **or** 1 Licensed[x] **and** 1 CSAC[x]

[x] Includes those in their regulatory board approved residency/supervisee/trainee status in accordance with DHP regulations.

• Assessments must be conducted by a LMHP, LMHP-S, LMHP-R, LMHP-RP either in-person or through a telemedicine assisted assessment.
• Pre-admission screenings must be provided by DBHDS certified pre-screeners. If the DBHDS certified pre-screener is not a LMHP, LMHP-R, LMHP-RP or LMHP-S, the pre-screening must be directly supervised and signed off by an LMHP.
• Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC-Supervisee*.
• Care Coordination must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC-Supervisee*, CSAC-A*
• Crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
• Health literacy counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CSAC* or CSAC-Supervisee*
• Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist.
• Individual and Family Therapy must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S.

**CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2*

Mobile Crisis Response Medical Necessity Criteria

All Mobile Crisis Response staff must be in possession of a working communication device in order to provide care coordination, engage natural/family supports and link the individual to needed follow-up services.

Admission Criteria: Diagnosis, Symptoms, and Functional Impairment	This service is available to any individual meeting the below criteria, regardless of diagnosis. Individuals must meet **all** of the following criteria: 1. The individual must be in an active behavioral health crisis that was unable to be resolved by the crisis call center phone triage process or other community interventions; 2. Immediate intervention is necessary to stabilize the individual's situation safely; 3. The individual or collateral contact reports at least **one** of the following: 1. suicidal/assaultive/destructive ideas, threats, plans or actions; 2. an acute loss of control over thoughts, behavior and/or affect that could result in harm to self or others; or 3. functional impairment or escalation in mood/thought/behavior that is disruptive to home, school, or the community or impacting the individual's ability to function in these settings; and/or; 4. the symptoms are escalating to the extent that a higher level of care will likely be required without intervention; 4. Without immediate intervention, the individual will likely decompensate which will further interfere with their ability to function in at least one of the following life domains: family, living situation, school, social, work, or community
Exclusion Criteria	Consent for a voluntary evaluation and mobile crisis response intervention is refused.
Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment	Not available for this level of care.
Discharge Criteria	Any one of the following criteria must be met: 1. The assessment and other relevant information indicate that the individual needs another level of care, either more or less intensive and that level of care is sufficiently available; 2. The individual is linked or transferred to an appropriate treatment setting based on the assessment and resolution; 3. Consent for treatment is withdrawn except during mandated assessments under the Code of Virginia §37.2-800 et. seq. for adults and §16.1-335 et seq. for youth under age eighteen; or 4. A Temporary Detention Order has been issued.
Mobile Crisis Response Service Authorization and Utilization Review	

Service Authorization	Mobile Crisis Response reimbursement is authorized by a registration process for eight hours (32 units) in a 72 hour period. Submission of registrations must be within 1 business day of admission. Concurrent registrations are allowable for mobile crisis response only if a pre-screening evaluation is needed to allow the pre-screening to be billed. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements. The individual's clinical record must reflect either resolution of the crisis which marks the end of the current episode or the discharge plan to an appropriate service to manage the ongoing symptoms associated with the crisis.

Mobile Crisis Response Billing Requirements

1. One unit of service equals 15 minutes.
2. To bill for a team Medicaid rate for team compositions #2 - #5, both team members must be present for the duration of the unit billed. The exception to this rule is when one team member separates from their teammate and the individual participating in the service in order to conduct care coordination activities.
3. Unlicensed staff working physically alone without their teammate in team compositions #2-5 do not meet the staff qualifications required to receive Medicaid reimbursement. The exception to this rule is when the unlicensed staff has separated from their teammate and the individual participating in service in order to conduct care coordination activities.
4. DBHDS certified pre-screeners billing for the purpose of conducting a prescreening must be a LMHP, LMHP-R, LMHP-RP or LMHP-S or directly supervised and signed off by an LMHP.
5. Mobile Crisis Response teams must be engaged and actively delivering one of the service components with the eligible individual, family member or collateral contact during the time billed in order to qualify for reimbursement.
6. Teams that consist of two LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss (any combination) may bill using the HT modifier even if one of the team members is not registered with DHP as a QMHP.
7. Providers of telemedicine assisted assessment should follow the provision of telehealth described in the "Telehealth Services Supplement". Mobile Crisis Response services are not eligible for originating site fee reimbursement. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Unit	Description	Notes	Provider Qualifications
H2011 and modifier (s) as appropriate	Per 15 minutes	Mobile Crisis Response		Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)

Team Composition(s) #	**Modifier**	**Modifier Meaning**
1	HO	1 Licensed[x]
	32	Prescreening under an Emergency Custody Order (ECO) 1 Certified Pre-screener (LMHP, LMHP-R, LMHP-RP or LMHP-S) or QMHP-A/QMHP-C directly supervised by an LMHP
	HK	Prescreening not under an ECO 1 Certified Pre-screener (LMHP, LMHP-R, LMHP-RP or LMHP-S) or QMHP-A/QMHP-C directly supervised by an LMHP.
2	HT, HM	1 QMHP-A/QMHP-C/CSAC[x] **and** 1 PRS **or** 1 QMHP-A/QMHP-C/CSAC[x] **and** 1 CSAC-A
3	HT, HO	1 Licensed[x] **and** 1 PRS **or** 1 Licensed[x] **and** 1 CSAC-A **or**
4	HT, HN	2 QMHPs (QMHP-A, QMHP-C, QMHP-E) – cannot consist of 2 QMHP-Es **or** 2 CSACs[x] **or** 1 QMHP-A/QMHP-C **and** 1 CSAC[x]
5	HT	1 Licensed[x] **and** 1 QMHP(QMHP-A, QMHP-C or QMHP-E) **or** 1 Licensed[x] **and** 1 CSAC[x]

[x] Includes those in their regulatory board approved residency/supervisee status in accordance with DHP regulations.

Community Stabilization

Community Stabilization Level of Care Guidelines

Service Definition	Community Stabilization services are short-term and designed to support an individual and their natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community stabilization services in an individual's natural environment and provide referral and linkage to other community-based services at the appropriate level of care. Interventions may include brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring intellectual/developmental disabilities and substance use are also available through this service. Services should involve advocacy and networking to provide linkages and referrals to appropriate community-based services and assisting the individual and their family or caregiver in accessing other benefits or assistance programs for which they may be eligible. The goal of Community Stabilization services is to stabilize the individual within their community and support the individual and/or support system during the periods 1) between an initial Mobile Crisis Response and entry in to an established follow-up service at the appropriate level of care 2) as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access or 3) as a diversion to a higher level of care.

Critical Features & Service Components	Community Stabilization is an alternative to or diversion from inpatient hospitalization, Residential Crisis Stabilization Unit (RCSU), or other, more intensive level of care. Community Stabilization teams must be available to provide services to an individual in their home, workplace, or other convenient and appropriate setting and must be able to provide services 24 hours per day, 7 days per week. Critical Features of Community Stabilization include: • Recovery-oriented, trauma-informed, culturally congruent and developmentally appropriate provision of services, integrating the Zero Suicide/Suicide Safer Care principles; • Assessment and screening, including explicit screening for suicidal or homicidal ideation; • Brief Therapeutic Interventions; • Skill Building; • Interventions to integrate natural supports in the de-escalation and stabilization of the crisis; • Health Literacy / Psychoeducation; • Crisis education and prevention planning and support; • Engaging peer/natural and family support to strengthen the individual's participation and engagement; • Linkage and referral to ongoing services, supports and resources (examples: housing, peers, chaplaincy), as appropriate and least restrictive level of care. Covered Services components of Community Stabilization include: • Assessment • Treatment Planning • Individual and Family Therapy • Crisis Intervention • Care Coordination • Peer Recovery Support Services • Health Literacy Counseling • Skills Restoration

Required Activities	The following required activities apply to Community Stabilization: • The provider must engage with the crisis call center in accordance with DBHDS requirements prior to initiating services. • At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S must conduct an assessment to determine the individual's appropriateness for the service. This assessment must be done in-person or through a telemedicine assisted assessment. The assessment requirement can be met by one of the following: 1. Providers may choose to complete a Comprehensive Needs Assessment (see Chapter IV for requirements). 2. If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment. 3. A DBHDS approved assessment for crisis services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. • A Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements is required for Community Stabilization and must be current. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. • If an individual is transitioning between crisis services, the provider may review and update an existing CEPP in accordance with DBHDS guidelines. • CEPPs must be reviewed and updated according to DBHDS requirements as an individual moves between crisis services. • Services must be provided in-person with the exception of the telemedicine assisted assessment and care coordination. • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: Community Stabilization may not be billed concurrently beyond a seven day overlap with any Community Mental Health Rehabilitative Services (CMHRS), Enhanced Behavioral Health (EBH) Services or Addiction and Recovery Treatment Services (ARTS). Community Stabilization shall not be delivered in inpatient hospitals, psychiatric residential treatment facilities, therapeutic group homes or ASAM levels 3.1 – 4.0. A 48 hour overlap in services as an individual is transitioning from an inpatient hospital to a community setting is allowed. Services shall not be provided for the sole reason of providing temporary housing to an individual; if the individual meets other admission criteria and housing is an additional assessed need, this should be noted on the service authorization request to support continued coordination of resources for the individual. • - ■ Activities that are not reimbursed or authorized: - Inactive time or time spent waiting to respond to a behavioral situation; - Time spent in documentation of individual and family contacts, collateral contacts, and clinical interventions; - Supervision hours of the staff; - Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers; - Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision; - Respite care; - Transportation for the individual or family. Additional medical transportation for service needs not considered part of Community Stabilization services may be covered by the transportation service through the FFS Non-Emergency Medical Transportation Broker or MCO. Medical transportation to Community Stabilization providers may be billed to the transportation broker; - Covered services that have not been rendered; - Services not in compliance with Code of Virginia, the Mental Health Services Manual or licensure standards; - Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's crisis/safety plan(s); - Services provided that are not within the provider's scope of practice; - Anything not included in the approved service description; - Changes made to the service that do not follow the requirements outlined in the provider contract, provider manual, or licensure standards; or - Any intervention or contact not documented or consistent with the goals, objectives, and approved services of the provider contract, service manual, or licensure standards
Community Stabilization Provider Participation Requirements	

<table>
<tr><td>Provider Qualifications</td><td>Community Stabilization service providers must be licensed by DBHDS as a provider of Crisis Stabilization services and be credentialed with the individual’s Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS.
Community Stabilization providers must follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS required training for this service.
Community Stabilization Teams must have an active Memorandum of Understanding with the regional crisis hub via DBHDS by June 30, 2022.</td></tr>
<tr><td>Staff Requirements</td><td>Community Stabilization service providers may offer delivery of the service through different staffing complements depending on what activities are being delivered and what staffing is required to provide such activities. Providers must bill using the modifier associated with the team delivering the covered service component.

<table>
<tr><th>#</th><th>Staffing/Team Composition (s)</th></tr>
<tr><td>1</td><td>1 QMHP-A or QMHP-C or 1 CSAC[x]</td></tr>
<tr><td>2</td><td>1 Licensed[x]</td></tr>
<tr><td>3</td><td>1 Licensed[x] <u>and</u> 1 PRS or
1 Licensed[x] <u>and</u> 1 CSAC-A</td></tr>
<tr><td>4</td><td>1 Licensed[x] <u>and</u> 1 QMHP-E or QMHP-C or QMHP-A or
1 Licensed[x] <u>and</u> 1 CSAC[x]</td></tr>
</table>
[x] Includes those in their regulatory board approved residency/supervisee status.
• Assessments must be provided by a LMHP, LMHP-S, LMHP-R, LMHP-RP.
• Care Coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
• Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, or CSAC Supervisee*
• Crisis intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*.
• Individual and Family Therapy must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S.
• Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist.
• All Community Stabilization staff must be in possession of a working communication device in order to provide care coordination, engage natural/family supports and link the individual to needed follow-up services.

*CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2</td></tr>
<tr><td colspan="2">Community Stabilization Medical Necessity Criteria</td></tr>
</table>

Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Individuals must meet **all** of the following criteria: 1. 1. 1. 1. The individual has experienced a recent behavioral health crisis (within 72 hours of admission) or the individual is transitioning from or at risk of a higher level of care and requires short-term support with identifying and engaging in the services necessary to maintain safety and stability in the community; 2. Documentation indicates evidence that the individual meets criteria for a primary diagnosis consistent with the most recent version of the Diagnostic and Statistical Manual; 3. There is evidence from the individual or collateral contact indicating **at least one** of the following is present: 1. High potential for crisis-cycling without this support; 2. Individual does not have the ability and/or the resources to support maintenance of safety and/or stability in the community until longer term services are available/accessible; 3. Individual has been engaged in alternative crisis services or treatment and no longer meets criteria for those services but continues to require community stabilization support; 4. The individual currently has moderate to high intensity behavioral and/or emotional needs and without intervention, will further interfere with their ability to function in at least one life domain: family, living situation, school, social, work or community.
Exclusion Criteria	Individuals who meet any of the following criteria are not eligible to receive Community Stabilization services: 1. The individual's psychiatric condition is of such severity that it can only be safely treated in a 23-hour crisis stabilization, residential or inpatient setting; 2. The individual's acute medical condition is such that it requires treatment in an acute medical setting; 3. The individual/parent/guardian does not voluntarily consent to treatment.
Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment	All of the following criteria must be met: 1. The individual's condition continues to meet admission criteria at this level of care; The individual's treatment may require a more-intensive level of care but the appropriate service is not available/accessible at this time; 2. Treatment is rendered in a clinically appropriate manner and is focused on the individual's behavioral and functional outcomes as described in the treatment and discharge plan; 3. Treatment planning is individualized and appropriate to the individual's developmental level and changing condition, with realistic, specific, and attainable goals and objectives stated. CEPP should include support system involvement unless contraindicated; 4. There is documented, active discharge planning starting at admission; and 5. There is documented active coordination of care with other service providers. If care coordination is not successful, the reasons are documented, and efforts to coordinate care continue.

Discharge Criteria	Any of the following criteria is sufficient for discharge from this level of care: 1. The individual no longer meets admission criteria; 2. CEPP has been sustained appropriately and/or a safe, discharge plan is arranged and services at an appropriate level of care have been initiated; 3. The individual and/or support system is not engaged in treatment. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues; 4. Consent for treatment is withdrawn; 5. Support systems that allow the individual to be stabilized while being connected to a more appropriate level of care have been secured; 6. The individual is not able to sustain the CEPP, and there is no reasonable expectation that they will be and escalation to a higher level of care is necessary; 7. The individual's physical condition necessitates transfer to an acute, inpatient medical facility.
Community Stabilization Service Authorization and Utilization Review	
Service Authorization	Community Stabilization reimbursement is initially authorized through a registration process for seven calendar days/112 units. Submission of registrations must be within one business day of admission. If additional activities beyond seven calendar days or 112 units are clinically required, the provider must submit an authorization request to the FFS contractor or MCO through a continued stay service authorization request accompanied by a CEPP. The continued stay service authorization request must be submitted no earlier than 48 hours before the requested start date of the continued stay and no later than the requested start date. Consecutive registrations from the same or different provider are not permitted with the exception of individuals moving out of the catchment area during the registration period. If an individual moves during the initial seven calendar day registration period and needs to transfer to another provider, a new registration is allowed but the total registration period between the two providers may not exceed seven calendar days/112 units. A continued stay service authorization is always required beyond the initial seven calendar days/112 units. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.

Community Stabilization Billing Requirements

1. One unit of service equals fifteen minutes.
2. The staff who deliver the activities for each contact determine the billing code modifier and the reimbursement rate associated with that unit of service.

3. To bill for a team Medicaid rate for team compositions #3 - #4, both team members must be present for the duration of the unit billed.
4. Staff working physically alone without their teammate in team compositions #3-4 are not allowed to bill the team Medicaid reimbursement rate. If only one member of the team is required based on the individual's treatment needs, the provider may bill for staff compositions #1 or #2 depending on the credentials of the staff member providing the service.
5. Community Stabilization staff must be engaged and actively delivering services to the eligible individual, family member or collateral contact during the time billed.
6. Teams that consist of two LMHPs, LMHP-Rs, LMHP-RPs or LMHP-Ss (any combination) may bill using the HT modifier even if one of the team members is not registered with DHP as a QMHP.
7. Providers of telemedicine assisted assessment should follow the provision of telehealth described in the "Telehealth Services Supplement". Providers should not bill originating site fees. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Unit	Description	Notes	Provider Qualifications
S9482 with appropriate modifier	Per 15 minutes	Community Stabilization		Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)

Staff/Team Composition #	**Modifier**	**Modifier Meaning**
1	HN	1 QMHP-A or QMHP-C or 1 CSAC[x]
2	HO	1 Licensed[x]
3	HT, HM	1 Licensed[x] **and** 1 Peer **or** 1 Licensed[x] **and** 1 CSAC-A
4	HT	1 Licensed[x] **and** 1 QMHP-E or QMHP-C or QMHP-A **or** 1 Licensed[x] **and** 1 CSAC[x]

[x] Includes those in their regulatory board approved residency/supervisee status.

23-Hour Crisis Stabilization

23-Hour Crisis Stabilization Level of Care Guidelines	
Service Definition	23-Hour Crisis Stabilization provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis for a period of up to 23 hours in a community-based crisis stabilization clinic which includes outpatient hospital settings that have a Community Stabilization license. This service must be accessible 24/7 and is indicated for those situations wherein an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or residential crisis stabilization unit setting is necessary. This service allows for an opportunity for thorough assessment of crisis and psychosocial needs and supports throughout the full 23 hours of service to determine the best resources available for the individual to prevent unnecessary hospitalization.
Critical Features & Service Components	23-Hour Crisis Stabilization is appropriate for individuals who have emergent behavioral health needs including but not limited to significant emotional dysregulation, disordered thought processes, substance use and intoxication and environmentally de-stabilizing events that require multi-disciplinary crisis intervention and observation to stabilize the immediate crisis and determine the next appropriate step in the plan of care. This service also includes screening and referral for appropriate behavioral health services and community resources. This service is provided in a community-based crisis stabilization clinic that has referral relationships to both outpatient and inpatient levels of care as next level of care options. Critical Features/Covered Service Components of 23-Hour Crisis Stabilization include: • Assessment • Psychiatric Evaluation • Individual and Family Therapy • Treatment Planning • Crisis Intervention • Care Coordination • Skills Restoration • Peer Recovery Support Services • Health Literacy Counseling / Psychoeducation Activities

Required Activities	The following required activities apply to 23-Hour Crisis Stabilization: • At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment to determine the individual's appropriateness for the service. The assessment requirement can be met by one of the following: 1. Providers may choose to complete a Comprehensive Needs Assessment (see Chapter IV for requirements). 2. A prescreening assessment completed by the provider. 3. If a prescreening assessment has been completed within 72 hours prior to admission by another provider, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment. 4. A DBHDS approved assessment for 23-hour crisis stabilization services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. 5. For individuals admitted with a primary diagnosis of substance use disorder, a multidimensional assessment meeting the criteria in Chapter IV of the Addiction and Recovery and Treatment Services Manual. • A psychiatric evaluation by a psychiatrist, nurse practitioner or physician assistant must be available at admission into the service. • 23 hour crisis stabilization providers shall have 24 hour in-person nursing. Nursing can be shared among co-located programs as long as all individuals presenting for services receive a nursing assessment to determine current medical needs, if any, at admission. • The Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements is required for this service and must be current. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. • CEPPs must be reviewed and updated according to DBHDS requirements as an individual moves between crisis services. • Coordination of withdrawal management services with a medical provider is required as necessary including medication and clinical supports. • The following components must be available to individuals in the treatment program: 1. Individualized treatment planning; 2. Individual, and family therapy 3. Nursing on-site 24/7; 4. Skill restoration/development and health literacy counseling/psychoeducational interventions; 5. Psychiatric evaluation as well as additional clinically indicated psychiatric and medical consultation services must be available; 6. Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral; 7. Crisis intervention and safety planning support available 24/7; 8. Peer recovery support services, offered as an optional supplement for individuals; 9. Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following: • The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care; • The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served; • The provider shall collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers. • At a minimum, required components of 23 hour crisis stabilization include: assessment, psychiatric evaluation, a nursing assessment and care coordination. • Services must be provided in-person with the exception of the psychiatric evaluation and care coordination.

Service Limitations	The individual cannot have participated in 23-Hour Crisis Stabilization in the last 24 hours. Services may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010. Services may not be billed concurrently with Psychiatric Residential Treatment Facility services, Therapeutic Group Home services, Inpatient Psychiatric services or ARTS ASAM levels, 3.1, 3.3, 3.5, 3.7 and 4.0. In accordance with DBHDS licensing regulations, 23-Hour Crisis Stabilization is a center based service and must be provided in a specific location that is approved and licensed. Services must be provided in a licensed program that meets DBHDS physical site requirements and may not be provided in other locations outside of the licensed site. Services shall not be provided for the sole reason of providing temporary housing to an individual; if the individual meets other admission criteria and housing is an additional assessed need, this should be noted on the service authorization request to support continued coordination of resources for the individual. In addition to the “Non-Reimbursed Activities for all Mental Health Services” listed in Chapter 4 of this manual, activities not authorized or reimbursed within 23-Hour Crisis Stabilization include: • Contacts that are not medically necessary; • Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor; • Transportation • Covered services that have not been rendered. • Any intervention or contact not documented or consistent with the approved CEPP goals, objectives, and approved services.
23-Hour Crisis Stabilization Provider Participation Requirements	
Provider Qualifications	23-Hour Crisis Stabilization service providers must be appropriately licensed by DBHDS as a crisis stabilization provider and be credentialed with the individual’s Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS. 23-Hour Crisis Stabilization providers must follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS required training for this service.

Staff Requirements	23-Hour Stabilization services involve a multi-disciplinary team of physicians, nurses, LMHPs, LMHP-R, LMHP-RP, LMHP-S, QMHP-As, QMHP-Cs, QMHP-Es, CSACs CSAC-Supervisees, CSAC-As, RNs, LPNs and/or registered peer recovery specialists within their scope of practice. Residential aide level staff can also provide services under the supervision of an LMHP. These programs must be supervised by a LMHP who is acting within the scope of their professional license and applicable State law. A licensed psychiatrist or psychiatric nurse practitioner (who is acting within the scope of their professional license and applicable State law) must be available to the program 24/7 either in person or via telemedicine to provide assessment, treatment recommendations and consultation. Nursing services must be provided by either a RN or a LPN who is present on the unit. The LPN must work directly under the supervision of an RN in accordance with 18VAC90-19-70. Assessments must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP Individual and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC* or CSAC Supervisee* Health literacy counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management. Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*. Skills restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or a residential aide under the supervision of at least a QMHP-A or QMHP-C. Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*. Peer recovery support services must be provided by a Registered Peer Recovery Specialist. **CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2* RNs, LPNs, and Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine.
23-Hour Crisis Stabilization Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	All of the following criteria must be met: • Demonstrated symptoms consistent with an International Statistical Classification of Diseases and Related Health Problems (ICD) diagnosis that correlates to a Diagnostic and Statistical Manual (DSM) within the last 24 hours; • Indication that the symptoms may stabilize within a 23 hour period at which time a less restrictive level of care will be appropriate OR the nature of the symptoms (e.g. intoxication is present and potentially layered with mental health crisis) require a period of observation in order to determine the appropriate level of care for the individual; • The presenting clinical problem requires a safe, contained environment wherein observation and assessment can be conducted to determine next steps in the individual's care.
Exclusion Criteria	The individual is not appropriate for this service if there is a presence of any condition of sufficient severity to require acute psychiatric inpatient, medical, or surgical care.

Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment	There is no continued stay for this service, the service is a total maximum of 23 hours per episode.
Discharge Criteria	Regardless of the individual's clinical status, the service requires that individuals are discharged within 23 hours. The point at which that discharge occurs within that time frame may depend on: • Whether the individual no longer meets admission criteria or meet criteria for a less or more intensive level of care; • Determination and availability of the service or natural supports to which the individual is to be discharged into the care of; • The individual does not voluntarily consent to admission with the exception of temporary detention orders pursuant to §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia;
23-Hour Crisis Stabilization Service Authorization and Utilization Review	
Service Authorization	23-Hour Crisis Stabilization is authorized through a registration process for one 23-hour episode/one unit. Submission of registrations must be within one business day of admission. Consecutive registrations from the same or different provider are not permitted. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	The individual's clinical record must reflect either resolution of the crisis which marks the end of the current episode or the discharge plan to an appropriate service to manage the ongoing symptoms associated with the crisis. Refer to Chapter VI of this manual for documentation and utilization review requirements.

23-Hour Crisis Stabilization Billing Requirements

1. One unit of service equals 23.00 hours and is reimbursed as a per diem.
2. The billing date is the day of admission and per diems cannot be billed on two consecutive calendar days.
3. If an individual is admitted to 23-Hour Crisis Stabilization and it is determined that RCSU services are needed, the provider should bill the first 23.00 hours with the 23-Hour Crisis Stabilization (S9485) procedure code and the Residential Crisis Stabilization Unit (H2018) procedure code for any subsequent 24-hour period. The provider should not bill multiple per diems for the first 24-hours of care and must request appropriate service authorizations for each service.
4. The same provider cannot bill multiple per diems in the same calendar day for 23-Hour Crisis Stabilization (S9485), RCSU (H2018) or ARTS services that are paid at a per diem rate.
5. Psychiatric evaluation may be provided through telemedicine. Providers should follow the provision of telehealth described in the "Telehealth Services Supplement". Providers should not use telemedicine modifiers or bill originating site fees. MCO contracted providers should consult with the contracted MCOs for their specific

policies and requirements for telehealth.

Billing Code	Modifier	Unit	Description	Notes	Provider Qualifications
S9485		Per Diem	23-Hour Crisis Stabilization		Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
S9485	32	Per Diem	23-Hour Crisis Stabilization – Emergency Custody Order	Billing modifiers are determined by the status of the individual at the time of admission.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
S9485	HK	Per Diem	23-Hour Crisis Stabilization – Temporary Detention Order	Billing modifiers are determined by the status of the individual at the time of admission.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)

Residential Crisis Stabilization Unit (RCSU)

Residential Crisis Stabilization Unit (RCSU) Level of Care Guidelines	
Service Definition	RCSUs provide short-term, 24/7, residential psychiatric/substance related crisis evaluation and brief intervention services. Residential Crisis Stabilization Units (RCSUs) serve as diversion or stepdown from inpatient hospitalization. The service supports individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning.

Critical Features & Service Components	This service occurs in a non-hospital, community-based crisis stabilization residential units with no more than 16 beds. RCSUs serve as primary alternatives to inpatient hospitalization for individuals who are in need of a safe, secure environment for assessment and crisis treatment. RCSUs also serve as a stepdown option from psychiatric inpatient hospitalization and function to stabilize and reintegrate individuals who meet medical necessity criteria back into their communities. RCSUs may co-locate with 23 Hour Crisis Stabilization. RCSUs may also provide medically monitored residential services for the purpose of providing psychiatric stabilization and substance withdrawal management services on a short-term basis; see provider qualifications and billing guidance for further details. Critical Features/Covered Service Components of RCSUs include: • Assessment • Treatment planning; • Health literacy counseling/Psychoeducation; • Skills restoration; • Peer recovery support services • Medical and nursing assessments and care; • Individual, group and/or family therapy; • Care coordination • Psychiatric evaluation • Crisis intervention

Required Activities	The following required activities apply to RCSUs: • At the start of services, a LMHP, LMHP-R, LMHP-RP or LMHP-S must conduct an assessment to determine the individual's appropriateness for the service. The assessment requirement can be met by one of the following: 1. Providers may choose to complete a Comprehensive Needs Assessment (see Chapter IV for requirements). 2. A prescreening assessment completed by the provider 3. If a prescreening assessment has been completed within 72 hours prior to admission, the LMHP, LMHP-R, LMHP-RP or LMHP-S may review and create an update or addendum to the prescreening assessment. 4. A DBHDS approved assessment for residential crisis stabilization services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. 5. For individuals admitted with a primary diagnosis of substance use disorder, a multidimensional assessment meeting the criteria in Chapter IV of the Addiction and Recovery and Treatment Services Manual. • A psychiatric evaluation by a psychiatrist, nurse practitioner or physician assistant must be available at admission into the service. • RCSU providers must have 24 hour in-person nursing. *(RCSU providers have until 11/30/2022 to fully meet this requirement)* Nursing can be shared among co-located programs as long as all individuals presenting for services receive a nursing assessment to determine current medical needs, if any, at admission. • The Crisis Education and Prevention Plan (CEPP) meeting DBHDS requirements is required for this service and must be current. The CEPP process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP or LMHP-S. • CEPPs must be reviewed and updated according to DBHDS requirements as an individual moves between crisis services. • Coordination of withdrawal management services with a medical provider is required as necessary including medication and clinical supports • The following components must be available to individuals in the treatment program. 1. Individualized treatment planning; 2. Individual, group and family therapies; 3. Nursing in-person 24/7*; 4. Skill restoration/development and health literacy counseling/psychoeducational interventions; 5. Psychiatric evaluation as well as additional clinically indicated psychiatric and medical consultation services must be available; 6. Medical, psychological, psychiatric, laboratory, and toxicology services available by consult or referral; 7. Crisis intervention and safety planning support available 24/7; 8. Peer recovery support services, offered as an optional supplement for individuals; 9. Care coordination through referrals to higher and lower levels of care, as well as community and social supports, to include the following: • The provider shall collaborate in the transfer, referral, and/or discharge planning process to ensure continuity of care; • The provider shall establish and maintain referral relationships with step-down programs appropriate to the population served; • The provider shall collaborate with the individual's primary care physician and other treatment providers such as psychiatrists, psychologists, and substance use disorder providers. **RCSU providers have until 11/30/2022 to fully meet this requirement.* • On the day of admission, at a minimum, RCSU providers must provide assessment, psychiatric evaluation and a nursing assessment. • To bill the per diem on subsequent days during the admission, providers must provide daily individual, group or family therapy unless the LMHP, LMHP-R, LMHP-RP or LMHP-S documents the reason why therapy is not clinically appropriate. In addition, providers must, at a minimum, provide daily at least two of the following: 1. crisis interventions 2. psychiatric evaluation 3. skill restoration/development 4. health literacy counseling/psychoeducation interventions 5. Peer recovery support services • Services must be provided in-person with the exception of the psychiatric evaluation and care coordination.

Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: RCSUs may not be billed concurrently with: • Addiction and Recovery Treatment Services at ASAM levels 2.1-4.0 • Applied Behavioral Analysis • Therapeutic Day Treatment • Mental Health Partial Hospitalization Programs • Mental Health Intensive Outpatient Services • Mental Health Skill Building • Intensive In-Home Services • Multisystemic Therapy • Functional Family Therapy • Psychosocial Rehabilitation • Assertive Community Treatment • Psychiatric Residential Treatment Facility (PRTF) Services • Therapeutic Group Home (TGH) • Inpatient hospitalization • A seven day overlap with any outpatient or community-based behavioral health service (including other crisis services) may be allowed for care coordination and continuity of care. In accordance with DBHDS licensing regulations, this service must be provided in a licensed program that meet DBHDS physical site requirements for the service. Services may not be provided in other locations outside of the licensed site. Services shall not be provided for the sole reason of providing temporary housing to an individual; if the individual meets other admission criteria and housing is an additional assessed need, this should be noted on the service authorization request to support continued coordination of resources for the individual. Services may not be provided in facilities that meet the definition of an Institutions of Mental Disease (IMDs) as defined in 42 CFR 435.1010 Activities that are not reimbursed or authorized: • Services not in compliance with Code of Virginia, the Mental Health Services Manual or licensure standards; • Anything not included in the approved service description; • Changes made to the service that do not follow the requirements outlined in the provider contract, provider manual, or licensure standards; or • Any intervention or contact not documented or consistent with the goals, objectives, and approved services of the provider contract, service manual, or licensure standards
Residential Crisis Stabilization Unit Provider Participation Requirements	
Provider Qualifications	Residential Crisis Stabilization Unit service providers must be licensed by DBHDS as a provider of Residential Crisis Stabilization Programs, Group Home Service REACH or DD Group Home Service REACH and be credentialed with the individual's Medicaid MCO for individuals enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for individuals in FFS. If RCSUs choose to provide ASAM 3.5 or 3.7-WM services, they must also be licensed for these ASAM services by DBHDS as required for those services. Residential Crisis Stabilization Unit providers must follow all general Medicaid provider requirements specified in Chapter II of this manual and complete DBHDS required training for this service.

Staff Requirements	Residential Crisis Stabilization Units must be staffed with a multi-disciplinary team of physicians, nurses, LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHP-As, QMHP-Cs, QMHP-Es, CSACs CSAC-Supervisees, CSAC-As, RNs, LPNs and a registered peer recovery specialist. Residential aide level staff can also provide services and support under the supervision of a QMHP-A or QMHP-C. A LMHP (who is acting within the scope of their professional license and applicable State law) must supervise this program. A licensed psychiatrist or psychiatric nurse practitioner (who is acting within the scope of their professional license and applicable State law) must be available to the program 24/7 either in-person or via telemedicine to provide assessment, treatment recommendations and consultation meeting the licensing standards for residential crisis stabilization and medically monitored withdrawal services at ASAM levels 3.5 and 3.7. Assessments must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP. Nursing services must be provided by either a RN or a LPN who is present on the unit. The LPN must work directly under the supervision of an RN in accordance with 18VAC90-19-70. Treatment Planning must be provided by an LMHP, LMHP-R, LMHP-RP, LMHP-S; QMHP-A, QMHP-C, QMHP-E, CSAC* or CSAC Supervisee* Individual, group, and family therapy must be provided by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. Health literacy counseling must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, Nurse Practitioner, Physician Assistant, CSAC*, CSAC Supervisee* or a RN or LPN with at least one year of clinical experience involving medication management. Crisis Intervention must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee* or CSAC-A*. Skills restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-A, QMHP-C, QMHP-E or a residential aide under the supervision of at least a QMHP-A or QMHP-C. Care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, CATP, QMHP-A, QMHP-C, QMHP-E, CSAC*, CSAC Supervisee*, or CSAC-A*. Peer Recovery Support Services must be provided by a Registered Peer Recovery Specialist. **CSACs, CSAC Supervisees and CSAC-As may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2* RNs, LPNs, and Nurse Practitioners shall hold an active license issued by the Virginia Board of Nursing. Physicians and Physician Assistants shall hold an active license issued by the Virginia Board of Medicine.
Residential Crisis Stabilization Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Individuals must meet **all** of the following criteria: 1. Documentation indicates evidence that the individual meets criteria for a primary diagnosis consistent with the most recent version of the Diagnostic and Statistical Manual 2. **One** of the following must be present: 1. The individual is currently under a Temporary Detention Order; 2. Abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning related to a behavioral health problem; 3. Actual or potential danger to self or others as evidenced by: 1. Suicidal thoughts or behaviors and/or recent self-injurious behavior with suicidal intent; or 2. Homicidal ideation; or 3. Command hallucinations or delusions 4. Significant loss of impulse control that threatens the safety of the individual and/or others or their ability to take care of themselves; 5. Significant inability to maintain basic care for oneself and to keep oneself safe in the community in an age appropriate manner that is not associated with Dementia; 6. Substance intoxication with suicidal/homicidal ideation or inability to care for self

Exclusion Criteria	Any one of the following criteria is sufficient for exclusion from this level of care: 1. The individual's psychiatric condition is of such severity that it can only be safely treated in an inpatient setting due to violent aggression or other anticipated need for physical restraint, seclusion or other involuntary control; or 2. The individual's medical condition is such that it can only be safely treated in a medical hospital as deemed by a physician; or 3. The individual does not voluntarily consent to admission with the exception of temporary detention orders pursuant to §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia; 4. The individual can be safely maintained and effectively participate in a less intensive level of care; or 5. The request for service authorization is being pursued to address a primary issue of housing need, including individuals who were in some form of housing placement prior to admission to the RCSU and are not currently allowed to return and do not meet medical necessity criteria; or 6. Admission does not meet medical necessity criteria and is being used solely as an alternative to incarceration.
Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment	**All** of the following criteria must be met: 1. 1. 1. 1. The individual continues to meet admission criteria 2. Another less restrictive level of care would not be adequate to provide needed containment and to administer care 3. Treatment is still necessary to reduce symptoms and improve functioning so that the individual may participate in a less restrictive level of care 4. There is evidence of progress towards resolution of the symptoms that are preventing treatment from continuing in a less restrictive level of care 5. The individual's progress is monitored regularly and the treatment plan is modified if the individual is not making substantial progress toward a set of clearly defined and measurable goals 6. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out 7. Individual/family/guardian/caregiver/natural support is participating in treatment as clinically indicated and appropriate, or engagement efforts are underway 8. Coordination of care and active discharge planning are ongoing, with goal of transitioning the individual to a less intensive level of care
Discharge Criteria	Any **one** of the following criteria must be met: 1. The individual no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive, and that level, and that level of care is sufficiently available; or 2. The individual or parent/guardian withdraws consent for treatment, and it has been determined that the individual or guardian has the capacity to make an informed decision or the court has denied involuntary treatment; or 3. The individual is not making progress toward goals, nor is there expectation of any progress and a different level of care is being recommended by the supervising LMHP; or 4. Functional status is restored as indicated by one or both of the following: 1. no essential function is significantly impaired; and/or 2. an essential function is impaired, but impairment is manageable at an available lower level of care
Residential Crisis Stabilization Service Authorization and Utilization Review	
Service Authorization	RCSU services are initially authorized through a registration process for five calendar days/ five units. Submission of registrations must be within one business day of admission. If additional activities beyond five calendar days/five units are clinically required, the provider shall submit an authorization request to the FFS contractor or MCO through a continued stay service authorization request accompanied by a CEPP submitted no earlier than 24 hours before the requested start date of the continued stay and no later than the requested start date. Consecutive registrations from the same or different provider are not allowed. A service authorization is required, if additional service is required beyond the five calendar days/five units. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.

Residential Crisis Stabilization Billing Requirements

1. One unit of service equals one calendar day and is reimbursed as a per diem.

2. Day of discharge is billable if the individual continues to meet the medical necessity and the minimum required activities to bill the RCSU per diem are met.

3. The same provider cannot bill multiple per diems in the same calendar day of 23-Hour Crisis Stabilization (S9485), RCSU (H2018) or ARTS services that are paid at a per diem rate.

4. If a provider is licensed for both RCSU and for the provision of ASAM Levels 3.5 and/or 3.7-WM, and an individual is admitted to the RCSU for withdrawal management services, the provider should bill for the Addiction and Recovery Treatment Services until withdrawal management is no longer needed. At that time they may submit a registration for RCSU services.

5. Individuals likely to need greater than 23 hours of stabilization should be directly admitted to RCSU versus admitting to 23-Hour Crisis Stabilization.
6. A psychiatric evaluation may be provided through telemedicine. Providers should follow the provision of telehealth described in the "Telehealth Services Supplement". Providers should not use telemedicine modifiers or bill originating site fees. MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Modifier	Unit	Description	Notes	Provider Qualifications

H2018		Per Diem			Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
H2018	32	Per Diem	Residential Crisis Stabilization Unit – Emergency Custody Order	Billing modifiers for dates of service are determined by the status of the individual at the admission, and any subsequent billing is determined by the status of the individual at 12:01am on the day of service.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
H2018	HK	Per Diem	Residential Crisis Stabilization – Temporary Detention Order	Billing modifiers for dates of service are determined by the status of the individual at the admission, and any subsequent billing is determined by the status of the individual at 12:01am on the day of service.	Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)